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ABSTRACT

The presentation focuses on forms of therapeutic tutoring (particularly in reading) with children and adolescents. Developments in educational therapy at the Tavistock Clinic in London are cited along with efforts in the United States. Educational therapy approaches to deal with the school dropout program in Holland are also described. The approaches use principles of psychotherapy (including countertransference) as well as remedial teaching (use of a tutor as a model). Educational therapy stresses the capacity to learn, which should be considered developmentally. (CL)

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LEARNING TO LEARN THROUGH EDUCATIONAL THERAPY

introducing the panel on educational therapies at the 61st Annual Meeting of the American Orthopsychiatric Association april 10,1984 in Toronto (Canada)

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Philip Veerman*

In some detective stories the detective is able to find a trail because the criminal goes back to the place of the crime.
With more and more school-dropouts the last years,specially in the big cities,different forms of educational therapy can be of great importance for the prevention of children and adolescents dropping out of school.
Maybe the discussion of today can help us to find the trail.
The ultimate solution for the problem of the raising number of school-dropouts will probabely never be found. One of the ways to help some children and adolescents are "educational therapies".
As good detectives we have to follow this trail. What could help,is that being on the grounds of the American Orthopsychiatric Association we are more or less back to the place of the crime: in march 1961 Mary Kunst presented a paper before this same forum called "remedial educational techniques as part of the treatment of children with learning inhibitions, tutoring by the therapist"[1] and in the American Journal of Orthopsychiatry of april 1965 Norman Prentice and Bessie Sperry published the important article "therapeutically oriented tutoring of children with primary neurotic learning inhibitions"[2].
We are grateful that the American Orthopsychiatric Association again gives a new impulse through this panel at their Annual Meeting,to enable an exhange of experiences and ideas about educational therapies today. Hopefully it will stimulate colleagues to go on with their exploratory travels into the relatively unknown terrain between psychotherapy and remedial teaching.

educational therapies: what's in a name

Personally I would have been happier if the title of this panel would have been "forms of therapeutic tutoring" instead of "educational therapies" because it could suggest that they are forms of psychotherapy,which in my opinion educational therapies are not.

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When "therapeutic tutoring" is used, it is clear that it is not a form of psychotherapy. Knowledge of psychotherapeutic principles and psychodynamic aspects of learningproblems are indispensable - which the word "therapeutic" indicates - but the accent is on the tutoring. This is my personal opinion about this form of help.

But even if others consider it a form of psychotherapy, one thing is clear: the form of help will be a kind of a "cocktail".

As with cocktails there are different ingredients which are mixes together, in therapeutic tutoring or educational therapies the role of the professional should combine both therapeutic and educational approaches. How carefully our colleagues in Chicago, Dallas and London, England have thought of ingredients that have to be in the cocktail, we will be hearing here this morning. We are happy that our colleagues are willing to share their experiences with us here, which might give us ideas and help us in our work with children and adolescents.

the Tavistock Clinic in London

In London, England a very important contribution was made in developping the "educational therapy"-method for remedial teachers. The Founder of this method was Irene Caspari[3]. Educational therapy is still after the death of Irene Caspari an integral part of the clinical work in the Tavistock's department for children and parents. One of the educational therapists Helen High[4] describes that the focus in educational therapy is on the "specific learning difficulty as the referred problem" and that direct teaching is a component of the educational therapy-process. Educational therapy combines the use of teaching skills and techniques with the application of insight derived from psychoanalysis. Helen High described that "some children(...)whose learning difficulties are associated with emotional problems can use this opportunity to separate out the emotional and the learning problem by finding a new way to show the underlying emotional conflicts".

From this article of Mrs. High, it is possible to get an impression how educational therapy is put into practice in England. We are happy that Mrs. Muriel Barrett of the Tavistock can tell us today more about it.

At the Tavistock Center[5] in London there are such courses as "training in educational therapy for remedial and other specialist teachers".

And since 1973 there is also an Association in the United Kingdom called the Forum for the Advancement of Educational Therapy. The F.A.E.T. publiches a newsletter and organizes scientific meetings. Many members are remedial teachers in so called "remedial departments" of schools, others work in child guidance clinics.

In individual educational therapy the educational therapist sees the child alone on a regular basis, usually for an hour at the time, once or twice a week.

Mrs. High has described that there can also be an indication for educationa therapy in a group with not more then six children. She says that children who have particular difficulty in the area of rivalry with siblings or peers, can be helped more effectively in a small group than by individual sessions, since the problems over sharing the adult and the materials do not come up if there are no other children present.

Helen High has described a number of aspects of the process of educational therapy. We will hear more about these aspects in individual educational therapy today from Mrs. Muriel Barrett, but I here will already give you two aspects described by Mrs. High, which I think are important.

The first is the part played by the expression of fantasies and feelings associated with acute anxiety which came up around the learning. The other one is the well known phenomenon from the therapeutic process, that of transference and counter-transference.

As Sandler[6] has described "the concept of counter-transference can readily be extended outside psychoanalytic treatment, and awareness of the counter-transference can be regarded as a useful element in any doctor-patient or therapist-patient relationship". Knowledge about the counter-transference is I think very important in this kind of work. Learning can become so easily an issue of a power struggle where the client <u>has</u> to learn from the tuter or therapist and is not learning because he/she wants it.

Helen High describes Peter: "the feelings Peter had in relation to his mother were transferred to me, as doubtless they were to his teachers too, and he viewed me as wanting to control and push him. My counter-transference reaction to this was to feel like controlling and pushing him. My observatio and understanding of what was happening helped me to avoid this trap".

We are happy that Mrs. Barrett from the Tavistock, where they have so much experience with educational therapy, is here and maybe we can learn from her to avoid more traps.

<u>what's been done in the United States</u>

As I already said: in march 1961 the clinical psychologist and educational therapist Mary Kunst spoke at the Annual Meeting of this Association about "tutoring by the therapist"[7], the integration of tutoring into the treatment experience. As one of the advantages of tutoring she described the opportunity for the therapist "to observe the child's actual struggle with reading or computation".

But of course there are also several dangers. "The child might feel

conditionally accepted only if he succeeds academically".
Another danger as she describes is "the temptation to be overly sensitive to pressures by parents and teachers for achievement".
When the therapist also tutors there might be this disadvantage described by Mary Kunst:" a child may use tutoring to avoid coming to grips with a more important therapeutic problem".
One of the problems of all these approaches we will hear of today and which can be read about in the literature,is to keep the "right balance": the focus can be too much on remedial teaching, but also too little. Maybe we can exhange some ideas and experiences about the right balance of learning in the sessions and the timing of it.
Worth mentionning here is also the doctoral work for Columbia University Teachers College,"therapeutic emphasis in remedial reading for maladjusted children"[8] of M.Sosnoff of 1961. He tried to come to "an integration of the principles and procedures of psychotherapy and teaching of remedial reading". His research was done in a residential setting "the Wiltwyck School for Boys" near Poughkeepsie,New York. Sosnoff wrote that there was "a need for a therapeutic approach,methods and procedures with a two-fold aim to teach and treat".(...)Remedial reading seemed to lend itself as a non-threatening,task oriented,therapeutic medium which necessitated the use of psychotherapeutic and educational principles,methods and procedures, a relatively new type of treatment for maladjusted schoolchildren with reading disability, namely remedial reading therapy".
It was found here that the experimental group,which received remedial reading therapy in addition to other therapeutic services available to both the experimental and control groups,showed greater improvement in reading and personal-social adjustment then the control group".
Today we will hear of another residential setting for children,namely Timberlawn Psychiatric Hospital in Dallas,Texas. The paper that will be presented by Dr. Mark Blotcky and Miss Andrea Lichtenstein will discuss the role of the teacher and the importance of education in the overall treatment approach of youngsters. It strikes me that in handbooks on residential treatment(see for instance "the other 23 hours"| of Trieschman Whittaker and Brendtro)relatively little is written about the school-aspect. The importance of the educational therapy work as an integrated part of a therapeutic teamwork cannot enough be stressed. In Timberlawn Psychiatric Hospital the teacher is,as it was also described by Wolff et al[9], here an important member of the treatment team. We will hear today how the integration of the role of the teacher in the team of Timberlawn took place.

I just presented to you a review of the different forms of educational therapies. There are still a few forms which I have to tell you about to complete the picture.

In 1976 Leatrice Schacht, Walter Kass and Mervyn Schacht presented in Montreal an interesting paper "personality development and learning disabilities: long term follow-up of psychotherapeutic remediation"[10]. The authors developped a combined treatment program that attends to both the emotional and the learning problems. This approach "combines the methods of psychodynamic psychotherapy with the techniques of special education and remediation, based on learning theory, knowledge of developmental sequences and insight related to intrapsychic events. It combines in a single person the tutorial function of a remedial educator and the therapeutic function of a psychotherapist". They called this treatmentapproach "psychotherapeutic remediation".

Three interesting forms of treatment were described by Norman Prentice and Bessie Sperry under the title "therapeutically oriented tutoring of children with primary neurotic learning inhibituons"[11]. Described were: brief tutorial interventions in psychotherapy, a collaberative program of tutoring and therapy by a tutor and a therapist and last but not least "therapeutic tutoring". This last form combines "the therapeutic and educational function", but retains as its primary emphasis the teaching approach.

With short tutorial interventions in psychotherapy, the psychotherapist is not going to undertake a systematic educational program, but is "directing his or her attention to the invasion of neurotic distortions". When both psychotherapist and a remedial teacher work together with a child, it is of course important that both respect each others work. And Prentice and Sperry point out the importance of good timing. They had the experience that a periode of psychotherapy should precede remedial teaching in order to give the child time to consolidate his relationship with the therapist. "For the same reason during the early phases of treatment tutoring should not occur more frequentely than therapy". They stress the importance of a remedial teacher's or tutor's role in "building ego-skills and constructive sublimations for the child, which will enable him to cope with reality more effectively". Receiving praise for "achieving a realistic goal" is often a new experience for these children.

The therapeutic tutor combines both therapeutic and educational approaches and must have, say Prentice and Sperry, "a sound working knowledge of psychodynamics". But with this framework of knowledge "his primary commitment should lie in the learning process, rather than in the eliciting of unconscious material".

In the process of this therapeutic tutoring some children will allow or

will introduce "actively material relating to the affective components of their learning problems". When it is felt that this is not an "avoidance technique" (to achieve not to work in the session for instance) the tutor may deal with the material "maintaining the major focus on tutoring". As a general principle Prentice and Sperry formulated that "the child's feelings should be refocussed on their relationship to his school work". This therapeutic tutoring appreach concurs with my experience at the Psychological Special Educational Institute (P.P.I.)in Amsterdam,Holland, that with many children and adolescents the learning itself is disturbed. As Templeton,Sperry and Prentice[12] expres it:"our technique is based on the assumption that the learning process itself has become the area of unconscious conflict".

This theoretical startingpoint[13] that "the capacity to learn"(a term stemming from D.W.Winnicott)itself is disturbed, and in my opinion should be considered to be a developmental line(A.Freud),does apply to the continuum:liability to become a school drop-out — temporarily becoming a school dropout — becoming a school dropout.

I have described to you several forms of educational therapypractice in several parts of the world. Now I would like to describe the Institute where I work in Amsterdam.The Institute works with the three groups on the continuum. After the description of the Institute I give you my personal view of therapeutic tutoring.

fighting the school dropout phenomenon in Amsterdam

Holland is a country with a population of about fourteen million inhabitants. In the whole of Holland there are more than a million pupils at schools for secondary education. The statistics tell us that 4.3% per year of these pupils leave their type[14] of school and go to a lower type of school and 2.4% leave the school alltogether without a diploma. So 6.7% leave school in these ways.

In the schoolyear 1980-1981 allmost 40.000 pupils were at schools for secondary education in Amsterdam[15].At the end of this schoolyear 6.5% of the pupils left their type of school to go to a lower type and 4.5% left the school definitively without a diploma. So, 11% left school in these ways. Specially in Amsterdam more pupils drop out of the schools for junior general secondary education (M.A.V.O.) and schools for junior secondary vocational education (L.B.O.). The percentage of pupils leaving schools for junior general secondary education to go to a lower type of school,but also the percentage of pupils dropping out is two times higher in Amsterdam than the picture in the whole of Holland. The percentage of pupils coming from schools for junior secondary vocational education and leaving school all together is three times higher in Amsterdam

A review from the literature[16] suggests that a student's decision to leave school before graduation is nót an isolated decision, but "one based on many interactive factors, both personal and academic".
A recent research study by Zosja Berdowski[17] about the situation in Amsterdam concluded that the emotional and relational problems of pupils at schools for secondary education are highly responsible for them to play truant, but are hardly a reason to leave school. It seems that the schools can help the pupils with these problems better than with the problems around motivation and performance, the learning.
Here the Psychological Special Educational Institute("Stichting Psychologisch Pedagogisch Institute","PPI") plays an important role in the prevention of the school dropout-phenomenon, but also in the treatment of school dropouts. We work with primary-school children and adolescents liable to become school dropouts, but also with adolescents who temporarily became school-dropouts and adolescents who became school dropouts.
Five outpatient departments in different parts of the city of Amsterdam treat about 600 children and adolescents twice a week. They are referred by the school medical officer or by the school- social work and consulting teams in the city because their school/learning problems make them liable to become a school dropout.
Three relatively new projects of the Institute offer a day-program for 85 adolescents who have temporarily dropped out of school. The adolescents in these school dropout-projects are referred because they are motivated to returning to a school. Returning within a relatively short periode to school, still belongs to the possibilities. The work with these adolescents is concentrated around the (re)learning of a (day!)rhythm of learning, exploring their own capacities and making a realistic chice for a new schoo and the preparation for a placement at that school.
The so called "Daycenter" ("Dagopvang") works with about 150 adolescents who often for a long periode have not been attending a school. The Daycente focusses on developping a realistic perspective for the future. One's aim is to do this difficult task in about two years. After an orientation-periode in a group at the Daycenter, the adolescent is offered all kinds of group-experiences and activities and also has weekly talks with his/her own counsellor (the "mentor").
One of the clients of this Daycenter[18], a boy I will call here John, was 16 when he was referred to the Daycenter. At his school for senior general secondary education ("H.A.V.O.") he always had conflicts with his teachers, specially about rules. His intelligence was above avarage, but learning was a problem, because he could hardly concentrate. Therefore he was unable to advance to the next class/grade. But the extra year in this same class was also not a success and he was send to a school for

individualised education ("I.V.K.O."). Here he often played truant. In this same year he ran away from home. He started to live in houses of "squatterers"("in Dutch:"krakers") in Amsterdam. John's father committed suicide when John was six years of age. His mother had remarried; there were quarrels all the time at home.

Many of the adolescents who come to the Daycenter belong to certain groups: "skinheads", "punks" or "bombers". John is "punk".

At the Daycenter he wanted to find out what he wanted to do in life. He had no idea in which direction to look. At the Daycenter,where John stayed about one and a half year, a lot happened to him. When he came he was very difficult to handle. When the window was not opened at his request he just smashed the window. Other group-members were often frightened by his agressive behaviour. His involvement in the squatterers-movement in Amsterdam gave the counsellor in his group the idea of interesting him in journalism. She organized for him a fieldplacement at the local radiostation in Amsterdam. After this his behaviour changed: he stopped "blowing" so much as he used to do and was again interested in starting learningactivities. This was not too succesful: he could not concentrate. He now has a job with a construction-company.

Before describing to you some cases of the outpatient departments for children and adolescents who are liable to become school dropouts, the facilities at the other end of the continuum, I will first describe you a client[19] who was placed in one of the projects for adolescents who had temporarily become a school dropout. All these projects are in the same buildings as the outpatient departments. So,when an adolescent has gone back to a school of his/her choice and capacity, he/she is also placed in an outpatient-department where he/she can receive treatment from a therapeutic tutor. The adolescents can stay no longer than half a year in these projects. The client I will describe to you is Tim,who became a school dropout at the age of fourteen. At the school for junior secondary vocational education (L.T.S.) he had dropped more and more behind with his schoolresults,compared with other pupils. He could hardly say anything back to his peers,when they started teasing him. He started to play truant quite often. In the project he began to have more selfconfidence in his learning. He started to work here on the subjects that he liked and were also his best. Gradually he started to work on the more difficult subjects. the relatively small group of seventeen and the encouragement of the staff gave him sufficient security to enable him to attempt more contact with his peers. After a year Tim was ready to go to another school for junior secondary vocational education, where he would take a course in motor-vehicles. The counsellor and Tim visited the new school together the first time. After a short trial-periode Tim could graduate from the project where

he had normally spend twenty hours a week, and was placed in the outpatient department where he comes just twice a week.
I do not want to give you the impression that the clients in these projects are all so withdrawn as this boy. Take for instance Harry, another boy in one of these schooldropout-projects. He is sixteen years old. He has already had three schoolchanges. At all schools he was often suspended. It was difficult for him to suppress his impulses. He couldn't resist reacting to everything that was said in the classroom. In the project a beginning of selfreflection started. After several months in the group his reactions were not so fierce any more and he could be placed again at a school for junior secondary commercial education (L.E.A.O.). Only after a year of treatment in the outpatient department could his impulses come under the influence of his ego.
About these things we will hear more in the presentation of Marilyn Schuchman's paper "impulse control as a bridge to learning". Suppression of impulses is an important bridge to many things in life, but certainly to learning. It is an important angle of incidence.

<u>learning to learn</u>

At the outpatient departments the possibilities to develop a therapeutic-tutoring method are present. In an attempt to formulate[20] such a method I have explained that this method is <u>neither</u> a form of psychotherapy <u>nor</u> a form of remedial teaching. But the principles of both fields have been made use of (for example the establishment of a therapeutic alliance from the field of psychotherapy and thinking about your own style of learning - metacognition - from the field of special education, based on the cognitive learning theory).
At the end of the schoolyear a fourteen year old boy who goes to a school for senior general secondary education (H.A.V.O.) comes for the first time to the outpatient department of the Psychological Special Educational Institute. He is referred because he is hardly doing anything.
His intelligence is above avarage. He gives a very shy and closed impression. " He tries not to express his feelings and thoughts" writes the referring psychologist. At the beginning of the treatment there were sessions with Mother and David, as I will call him here. The school did not want to keep him on. Mother and David choose a school for junior general secondary education (M.A.V.O.). At this school David still isn't doing much in the first half year. At the Institute his attendance is also poor. He "forgets" his appointments and <u>if</u> he comes, he "forget" his books. After some months he starts to come more regular and his work at school improves. He shows the tuter proudly his tests. But while evaluating the material, the tuter asks himself if here a therapeutic alliance is established.

The tutor thinks that although the client comes now regularly to the Institute,this is probabely due to the fact that recentely there have been talks with his Mother.The tutor had choosen to make a coalition with mother in order to see if treatment should be continued and if so, to get David to school regulary. Therefore the tutor now invests time in finding something in common with David around the learning. After a while the therapeutic alliance grows and the client is more responsible: he now brings his homework to the Institute,doesn't forget his books and never forgets his appointments with his tutor. The case illustrates something very important in the treatment of these children and adolescents:the treatment will not be succesful when a therapeutic alliance is not established.This therapeutic alliance can be seen,as Sandler says, "as being based on the patient's conscious or unconscious wish to cooperate, and his readiness to accept the therapist's aid in overcoming internal difficulties. This is not the same as attending treatment simply on the basis of getting pleasure or some other form of gratification. In the treatment alliance there is an acceptance of the need to deal with internal problems"[21], Graafsma and Anbeek[22] have explained that there is a close relationship between a working-relationship and transference-feelings. There has to be a "fundamental transference"(Greenacre) in the beginning. So,the treatment starts often only with a positive transference.
The aim of the tutor has to be to establish a therapeutic alliance.
For a client to accept the help of a therapeutic tutor it is necessary that in his early years the client's ego-organisation got ,as Lampl-de Groo explains[23], "a certain amount of narcissistic cathexis". To have the feeling that one can use somebody else for his/her own health, a narcissistic tie in the past must have been established. As Mrs.Barrett will explain to you shortly in her presentation,such a "primary learning"-experience is assumed in educational therapy to have been "good enough" (in the Winnicott sense).
I recentely noticed that one of my adolescent girl-clients who regular comes,only comes to talk with the other girls and boys. She is not able to allow herself to use me as her "help-ego" for her problems with her schoolwork,despite every form of effort. I am afraid that I will not be succesful in establishing a therapeutic alliance with her. Such a therapeutic alliance one recognizes, says Meeks[24], "primarily through a subtle change in the tone of the sessions.(...)In short the therapist no longer feels that he is working totally alone in opposing the patient's resistances".
We see that many clients in the beginning start also with negative transference-feelings like "here I will again have a career of failures". It is of great importance for the treatment,that the tutor has an idea on what the learning-problem is based.

The tutor has to talk about the negative transference with the aim to promote a therapeutic alliance and head for the healthy parts of the clients personality. The territory about which the child or adolescent has a good feeling should be uses as a "sally-port". At the Institute we often start with a learning-activity about which the client has already a good feeling or he/she can do quite well. It can also be other activities as making cakes, painting or doing handicraft.
Nearly all clients who come to the outpatient departments of the Institute are greatly concerned about their learningabilities. The therapeutic tutoring-process has to give the clients hope again. Graafsma and Anbeek[25] have pointed out, in relation to the psychotherapeutic proces(but it also holds in therapeutic tutoring is my opinion), that it is not realized enough that dealing with resistance expressed in being not motivated, does not mean that the clients do not want to change. In other words: to take up the normal development is often present in an implicit way. The therapeutic alliance has to head for this normal development which is wanted to be restored by the clients.
To reestablish the normal development, it is necessary that the client overcomes the problems in reading, spelling and arithmatic. Here remedial teaching-techniques are an essential part of the method, unlike the practice in psychotherapy. When gaps in the knowledge of adolescents have to be overcome it is something very difficult, because working on these problems the adolescent often finds "childish". The tutor has to find work which the adolescent does not find childish and in which are all the elements to work on the specific learning problem. One of my clients, an adolescent in one of the last classes/grades of a school for junior general secondary education (M.A.V.O.) came a year ago to the Institute. His knowledge about the grammatical rules of the Dutch language is that of a child of eight years of age. We choose to work together on the preparatio of dictations he got in school. From these too difficult dictations, but for which he was motivated to work, I had to explain the grammatical rules to him. A "childish" book, probabely more appropriate, would have put him "off". One of my colleagues at the Institute uses for these purposes a small computer, for which adolescents are motivated to work with.
I am interested to hear experiences of my colleagues here about their work with adolescents.

Essential in this work is, in my impression, that the tutor is a "model" for the client; he has to show with his attitude that he finds learning of great importance. Slowly the client will imitate the model (the tutor). This and the idealizing will be internalized in the client.
Here it is important that the tutor doesn't get impatient, or uses means of power(like:"if you do not bring your work with you the next time, you can't

come here any more"). When a child or adolescent comes in a group, the groupmembers are also "models". Here it is necessary to place not too much "beginners" in one group, but also some groupmembers who are already working seriously. This gives the beginners hope.
The "climate" in the group is important. The tutor sets the tone here. Feelings of frustration, anxiety, anger and aversion can be discussed. The role of the tutor is comparable here with the role of a coach and his team. My clients turn the tutors (because of their transference feelings) into people, who have to keep them hard at their work or else they slip from the tutor's fingers. Many clients from the outpatient departments of the Institute are referred, because they hardly do their homework, often play truant, do not make a list of their homework in their schooldiaries, do not show much responsibility and from all feelings of unpleasure (like making a test at school) they run away. The school says it is also difficult to talk with them and calls these kids "unmotivated". Here the tutor faces a difficult problem: that of making demands.
- is the tutor making hardly any demands, the client is wronged by the tutor
- is the tutor making too much demands, there is the danger that the client will stay away from treatment.

The demands the tutor makes have to be reasonable.
The tutor has to be patient. "One of the hardly discussed countertransferen phenomena" wrote Sanders-Woudstra[26]. "is the disappointment in the child when it doesn't go as fast as the unpatient therapist had wanted.(...)This can lead to giving up therapy". And sometimes, wrote Sanders-Woudstra, the little progress in therapy is blamed on the parents.

A few remarks about parents have to be made here. It is very important that a workingalliance between the tutor and the parents is established. This is something else than taking the parents into therapy.
Marilyn Marder Schuchman will shortly discuss the family-therapy aspects of educational therapy. When we hear about these aspects it is also good to keep in mind Meeks wise words: "In practice, many parents do not consciously recognize any relationship between family problems and the symptoms of their adolescent. A fierce resistance is the only result if these parents are arbitrarily forced into a treatment -relationship. The most important factor to be considered in deciding wheter to refer parents for(...)casework is whether such a step is really necessary"[27]. Indication for taking parents into treatment is if they express a wish to be helped. When familyproblems or maritalproblems weigh much more heavy than the school/learning-problems, it is my opinion that a referral should be made to a mental health center where family therapy can be offered.

When a referral needs not to be made and family problems have a relation with the learningproblems of the client,the social workers of the department is the right person to go to. Like the nervous parents of the anxious girl who was só nervous about her tests at school,that in the middle of the night she would again start to do their work. They needed and asked help how to handle these problems.
Sometimes,although the parents are not taken into treatment themselves, a coalition must be made with them around the treatment of the child. Sometimes this is not possible. I had this disappointment with a mother of a fifteen year old boy at a school for junior secondary vocational education (L.T.S.),or more correct:was more outside(playing truant) than inside this school.He manipulated many times his mother to write letters to the school that he was sick,while he was in fact staying home not being sick. To talk with the mother about this was hardly possible because the mother did not show up at the Institute when we had an appointment, or she called that she had to do shopping.
For a succesful treatmentprocess,it is also important that there is a working alliance between the therapeutic tutor and the schoolteacher. A cooperation can prevent that problems grow out of hand (like behavioural problems and playing truant more and more). With teachers of primaryschool children the progress in treatment is the subject of the talk, and also problems and progress in school. The conversationsubjects between the child and the tutor are not discussed because this is of course confidentia

To conclude this discription of the outpatient departments,something should be mentionned which should be the "first strategy" [27] with all these clients who are liable to become school dropouts: in the department a therapeutic climate should be created in which the clients will be stimulated to be more selfconfident and in which they can express their feelings and in which they feel safe to experiment with other forms of behaviour[28]. The atmosphere in the Institute is very sociable and cosy. There is every opportunity for the clients to work in the kitchen,play tabletennis and take part in creative activities.
But this therapeutic climate must also stimulate the clients to do their schoolwork.

<u>the "capacity to learn"</u>

For educational therapies focussing on learning to learn,the "capacity to learn" is an important theoretical concept.
As we saw, principles of psychotherapy and remedial teaching have been made use of in educational therapies.

From the field of psychotherapy we have learned to establish a therapeutic alliance with the client. And the insights from psychodynamic psychology are of fundamental importance for the attempts to work in a methodical way. Important are also the "orthodidactic" - principles and strategies, based on the cognitive learning theory[30]. In learning, cognitive processes like perception, memory and attention play an important role.

The "capacity to learn" I see as a developmental line as described by Anna Freud[31].
The Russian psychologist Mëncinskaja also wrote about the capacity to learn. Reading an article of her hand in the translation on one of the Dutch professional journals[32], I have the impression that her concept of "capacity to learn" was introduced as an alternative for the concept of "psycho-neurological dysfunction", which cannot explain all learningproblems. Her concept of the "capacity to learn" is more or less a bridge between the personality variables and educational variables. She doesn't say this explicitely, but it looks like she sees the capacity to learn in a person as a static given fact, although less static than "psychoneurological dysfunction", because it can be affected by tutoring for instance.
My personal opinion is to see the capacity to learn more in a dynamic way as a specific ability which can - if necessary with the help of educational therapies - be developed.
As I said, it is important that this capacity to learn should be considered as a developmental line (from play to work) and this line can be devided in phases.
In my opinion it means that the capacity to learn can be disturbed <u>itself</u>. This means for the different forms of educational therapy, that we have to help the clients to pick up again the normal development.

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